

APPENDIX 2b
51.42 BOARD AODA SERVICES

PICA HEALTH INSURANCE CLAIM FORM PICA																																																																																																																																																																																																																																																																																	
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890																																																																																																																																																																																																																																																																												
2. PATIENT'S NAME (Last Name First Name Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																																																																												
5. PATIENT'S ADDRESS (No. Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																																																																																																																																												
CITY Anytown			STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY 																																																																																																																																																																																																																																																																									
ZIP CODE 55555			TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			ZIP CODE 																																																																																																																																																																																																																																																																									
9. OTHER INSURED'S NAME (Last Name First Name Middle Initial) OI-P					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																																																																																																																																																																																												
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																												
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																												
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																												
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																																																																																																																																																																																																																																																																												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																																																																																																																																	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																																																																																																																																												
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring					17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678																																																																																																																																																																																																																																																																												
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 303.91					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																												
23. PRIOR AUTHORIZATION NUMBER 1234567					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																												
24. DATE(S) OF SERVICE <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">From</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS EPSON OR Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th><th>MM</th><th>DD</th><th>YY</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th> </tr> </thead> <tbody> <tr> <td>01</td><td>14</td><td>92</td><td>21</td><td>28</td><td></td><td>3</td><td>1</td><td>W8975</td><td></td><td></td><td>1</td><td>XXX XX</td><td>3.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>01</td><td>14</td><td>92</td><td></td><td></td><td></td><td>3</td><td>1</td><td>W8979</td><td></td><td></td><td>1</td><td>XX XX</td><td>3.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr> <td colspan="22" style="text-align: right;">spenddown XX.XX</td> </tr> </tbody> </table>					A		B		C		D		E		F		G		H		I		J		K		From		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS EPSON OR Family Plan		EMG		COB		RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																	01	14	92	21	28		3	1	W8975			1	XXX XX	3.0									01	14	92				3	1	W8979			1	XX XX	3.0																																																																																																																																													spenddown XX.XX																						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
A		B		C		D		E		F		G		H		I		J		K																																																																																																																																																																																																																																																													
From		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS EPSON OR Family Plan		EMG		COB		RESERVED FOR LOCAL USE																																																																																																																																																																																																																																																													
MM	DD	YY	MM	DD	YY																																																																																																																																																																																																																																																																												
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spenddown XX.XX																																																																																																																																																																																																																																																																																	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED																																																																																																																																																																																																																																																																												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I.M. Provider MM/DD/YY SIGNED _____ DATE _____					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																																												
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					28. TOTAL CHARGE \$ XXX XX																																																																																																																																																																																																																																																																												
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 100 W. Williams Anytown, WI 55555 PIN# _____ GRP# 87654321					29. AMOUNT PAID \$ XX XX																																																																																																																																																																																																																																																																												
30. BALANCE DUE \$ XXX XX																																																																																																																																																																																																																																																																																	